

Clinical Section

*Some Recent Advances in Surgery

By

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The subject "Recent Advances" is a difficult one on which to speak. What is recent to one person often is not recent to another. The term "Recent" is only a relative one, and may mean anything from weeks to years. The term "Advance" is also difficult. What may appear to be an advance at the moment may be cast into the limbo in a year or so, because it is superseded by something better, or be found out to be false or useless. Occasionally what might be termed a "Recent Advance" is only the application of some drug or procedure which has been known for years. An example of this is one of the greatest advances in the whole realm of medicine—the use of Sulphanilamide. The drug was discovered by Gelmo in 1907. At that time he was a student in the Vienna Institute of Technology working on coal tar derivatives, and there he synthesized this product. He reported this work in his thesis in 1908. For some years after it was used in dyes, but it was not until about 1934 that Prontylin made its appearance in Germany. Levadite and co-workers discovered that the active principle was not Prontylin, but the substance Gelmo had described in 1908, consequently the name Prontylin only could be copyrighted, the substance itself could not be patented. I think we should all be thankful to Gelmo, who by the way may really deserve the credit, because it is not known whether Domagk and Klarer purposely built up Sulphonamide to conceal Sulphanilamide in the hope that it could be patented, but the fact that Gelmo had discovered the active principle prevented the Farben Industrie from getting a world patent, consequently the price of this drug has always been modest. Sulphanilamide is used in surgery with much the same indications as in the rest of medicine. In fact, it is being used so universally now that Colebrook has aptly made the remark that "one is far more likely to get Kudos from taking a patient off Sulphanilamide than from putting one on it." I think little need be said to this group about this drug and its related substances. I do not think there is any doubt that it has been one of the greatest advances in therapy in the last 20 years. It has been universally accepted. Its indications are gradually being worked out, and newer compounds developed from it for a wider use, especially against Staphylococci. This brings up an interesting point also. The first medical report on Sulphonamide was made in Germany in 1933

of a case of Staphylococcal Septicaemia cured with Streptozone, the name the Farben Industrie used before it applied the name Prontylin in 1934.

Blood Transfusion

Although blood was collected and stored for some days before an expected engagement by the R.A.M.C. in the first World War, the technique of using cadaver blood was introduced by Yudin of Moscow in 1930. Since then it has been found that cadaver blood can be stored for as long as 2 months.

Blood apparently does not become contaminated by bacteria, via the mesenteric vessels, for about 20 hours after death. The blood is drained off,—usually about 3500cc—nothing is added—the clot soon disappears by fibrinolysis, then it is refrigerated. It is unlikely that cadaver blood will become popular in Anglo-Saxon countries—most people have a repulsion about such things. The same end can be accomplished by the so-called blood bank. Grouped blood is removed from donors and stored in its appropriate group, and used when necessary. This method may become very popular during this war, blood being removed from the nearby civilian population and transported by air if necessary to the area needed.

Another method of collecting blood recently reported from Montreal is placental blood. About 125cc. of blood can be collected from the placenta when the cord is cut. This is run into citrate solution and refrigerated. This blood contains an excess of red cells averaging 7,000,000 per c.mm., so a quantity proportionately less is required.

Hormones and Vitamines

These substances are having their run in surgery as in the other branches.

A. P. L. has been used extensively in undescended testicles. There is no doubt that some undescended testicles can be made descend by the administration of these substances, but other visible changes sometimes occur, precocious puberty and penile hypertrophy. What other more serious and possibly more subtle changes go on, time will show. Many testicles that are in the canal will come down at puberty without any aid. Many that do not come down have an accompanying hernia which requires operative treatment, and both can be done at the same time.

It has always been difficult for me to understand the rationale of giving A. P. L. to unilateral cases of undescended testicles, if some force has acted to bring one testicle down, it must have acted on the other at the same time; and its failure to descend must be due primarily to some cause other than hormone deficiency.

In the case of under-developed boys with infantile genitals and bilateral cryptorchidism there is ample reason for hormone treatment.

* Presented at the Surgeons' Club of Winnipeg, February 1940.

The relationship of Vitamine A. to the formation of renal calculi is interesting. Some clinical observations have been known for a long time. Renal calculi are becoming increasingly rare in children. Apparently many years ago it was common to see a child with one. The native population of Johannesburg is nearly immune to stones, whereas in the white population the condition is frequent. In Germany and Austria there has been an increasing incidence since 1925, the time when those countries began to partake of what we call a more normal diet, and the word "normal" is here used in a guarded manner. Long and Pyrah of Leeds in a recently published article investigated 25 cases of kidney stones. 40% showed a definite sub-normal dark adaption estimated by use of a photometer. In 65 control cases none showed it.

It would appear that a low body reserve of Vitamine A. is commoner in people with urinary calculi than in those without.

I do not think there is enough evidence accumulated yet for anyone to say that Vitamine A. deficiency is the cause of the ordinary renal calculus—it may only be a factor.

One of the most unique advances is the new conception of the cause of some cases of haemorrhage associated with jaundice. Admittedly there are cases where there is scurvy or a liver so very badly damaged that it is incapable of forming prothrombin, but these are not the ordinary ones seen, that cause the surgeon such alarm. Operating on a jaundiced patient has always been a great hazard. When I was an interne calcium was used in all forms. The fact that some jaundiced patients never bleed was confusing, but when it occurred it might be into the skin from the nose, mucous surface or a newly formed wound. Mathew Baillie in 1795 observed that the blood in jaundice failed to coagulate after death, and thought this was due to "a chemical influence of a mixture of a certain proportion of bile with blood." The risk of haemorrhage increases with the depth of the jaundice, and it is the cause of 15% of the post-operative deaths of jaundiced patients.

Various factors have been investigated. Cholesterol, bile salts and bile pigments have not been proven to be the causal one.

Mayo Robson in 1894 was the first to suggest a calcium deficiency. Doyen in 1905 suggested a fibrinogen deficiency. Although this does occur in extensive hepatic disease, Leukaemia and as a congenital anomaly this has been proven not to be the cause in jaundice.

The present theory is that the bleeding is due to a deficiency of prothrombin. As you will remember in the presence of Calcium, thrombokinas activates normally present prothrombin and converts it into thrombin, which changes soluble fibrinogen into the insoluble gel, fibrin.

In 1935 Quick introduced his test. The basis of this test is to supply an optimum amount of all the factors required for coagulation except prothrombin. The coagulation time of the mixture will be inversely proportional to the amount of prothrombin present. The normal time is about 30 seconds. In deficiencies the time may be prolonged up to 100 seconds. Regardless of the pre-operative prothrombin value, there is usually a marked post-operative fall.

Dam in 1934 showed that haemorrhagic disease in chicks was accompanied by a reduction in prothrombin, and that this could be cured by the administration of certain dietary substances which have been called Vitamine K. This substance is abundant in alfalfa meal. Whether it is one or several substances has not yet been determined.

The two conditions in which the bleeding tendency is greatest is in obstructive jaundice and prolonged external biliary fistula. In both cases there is a deficiency of bile in the intestine.

In biliary disease cases there is a tendency for them to be put on a low fat diet, and so there is a deficiency in fat soluble substances including Vitamine K., consequently the liver is unable to manufacture prothrombin.

It was but a short step to use Vitamine K. and bile salts on the assumption that Vitamine K. was not absorbed from the intestine due to a lack of bile. If Vitamine K. is given alone some cases show no change in the prothrombin time until bile salts are added. This procedure does not entirely eliminate the danger of haemorrhage, but greatly reduces it.

Recently Macfie has used a substance 2; methyl 1—4 naphthoquinone which, if given intramuscularly, rapidly brings the prothrombin time to normal. Whether this is Vitamine K. or a similar substance is unknown as yet.

Manipulative Surgery

Although there have not been any marked advances in this branch of surgery, there has in recent years been a healthier attitude toward it. Because a method of treatment is not originally advocated by an orthodox medical man is not sufficient reason for medical men to condemn it, but they should use the method and exploit it to the full and so find out its value, and then try to use it intelligently. The advance in manipulative surgery is that it is becoming recognized as a very useful, excellent and often the only effective treatment for many painful and disabling complaints. Books are being written on it by leading members of the profession, and they are not being ostracized as was Wharton Hood, whose book, by the way, should be read by all surgeons.

Injection treatments, mainly directed against varicose veins, haemorrhoids and herniæ, are beginning to assume their proper place. None of these treatments are new. The injection of herniæ

dates back to at least 1830, and varicose veins to 1915.

I think it is fairly well accepted now that the injection of haemorrhoids is a useful palliative treatment for some of the symptoms. Early and bleeding cases can be made asymptomatic for a period of years, but recurrence is usual in about 5 to 8 years or earlier. The operation of haemorrhoidectomy is easy, safe and sure, and usually not painful, consequently the trend is back to operative cure rather than to syringefuls of palliation. But injection treatment here has many advantages. It is painless, it is inexpensive and there is no loss of time. If a person is busy and is losing a fair amount of blood and has no other complicating factors, it is a simple matter to thrombose the veins and stop the bleeding in 4 to 6 treatments. If bleeding returns, an operation can be done at a more convenient time.

Large varicose veins have a marked tendency to recanalize after injection unless their connection with the deep circulation has been severed. When recanalization takes place, valves that previously may have been inefficient are gone, and the recurrence is often more marked than the original lesion. If veins are large, and a free communication exists between the deep and superficial circulation, this communication should be closed by ligature before injections are proceeded with.

The antiquated method of treating herniæ has recently been resurrected. Heaton, the great advocate of this method from 1830 to 1850, used one substance, carbolic acid. At present the formulae advocated sound like the prescriptions of 200 years ago. The method certainly is not as dangerous as it was in Heaton's day, but I am sure it is not as efficient as some clinics would lead one to believe. Most papers from some centres put the % of cure in the 90's. Coley and his associates at the Hospital for the Ruptured and Crippled in New York in a recent paper put the failures at 100%. My personal experience falls about midway between. Several cases have remained cured for 3 years. Whether they will recur or not is problematical. I am inclined to think they will; one patient had an incarceration come on during injections; at operation the sac was greatly thickened and the neck contracted. Repair was difficult, but very efficient, the resulting canal feels like cement.

The question of testicular damage after injections usually crops up. Apparently this is rare, and very few cases have been reported.

There are many disadvantages to this method. First, it is not certain. No assurance can be given the patient that he will be relieved. I should say in favorable cases he has a 50-50 chance. The method is blind, and so is dangerous. Injury to viscera can occur, even with careful technique. Late recurrence, I am sure, will be high, unless the case is kept under observation and given reinforcing injections from time to time.

Surgical Technique

Many new procedures in technique have been introduced. One interesting but likely a not very important one is the introduction of ultra-violet lamps into operating rooms, to produce sterilization of the air. This is a shift back to the early Listerian era, when the air was filled with a fine carbolic acid vapour on the erroneous assumption that suppuration in a wound was due to organisms, entering via the air. The pathogenicity of the air likely varies directly in proportion to the amount of droplets of saliva, etc., present, and if efficient masks are worn by all people in an operating theatre air contamination drops to a negligible factor. Oddly enough I do not think there is one hospital in the city that has efficient masks.

There is a definite trend back to silk as being less irritating to tissue than large quantities of catgut. If this becomes a mass retreat the suture companies will very likely bring out newer types of catgut that are efficiently sterilized and that are stronger and consequently finer strands can be used. I think a good example of the mild irritation caused by catgut is a thyroidectomy wound—if heavy catgut is used there is much induration of the area and the wound tends to drain serum for many days. If silk is used this induration is not seen and drainage is minimal. Synthetic silk in the form of Nylon, the new fibre of the Dupont Company, is now on the market, and apparently is very non-irritating to tissue. This product will in time be very cheap, and may be extensively used.

The treatment of traumatic wounds will be of increasing interest because of the war. Most wounds, regardless of how dirty they are, if they are seen early, i.e., within 2 to 6 hours, can be prepared so that primary union occurs. Certain pre-requisites are necessary—no dead or damaged tissue must be left (except in face wounds). Scrupulous care in washing with soap and water, use of an irreducible amount of suturing material, and no suturing with any tension. The wound is then dressed and if no serious rise in temperature occurs no dressings are done. No antiseptics are used at any stage of the preparation.

This method of wound treatment is a combination of the extensive debridement used in the first Great War, and the Winnett Orr treatment of compound fractures. It was used extensively in the Spanish Civil War. Soft tissue wounds of extremities being encased in plaster, if suppuration occurs it is allowed to proceed. The pus collecting under the plaster likely producing a high bacteriophage content and being of real assistance in the healing instead of being religiously "cleaned" by the surgeon. It takes medical men a long time to get rid of the idea that pus is dirty. The only disagreeable feature is the smell, which at times can be very ripe. Compound fractures heal beautifully with this line of treatment, but one must have faith in the powerful

defences of the body and assist them by removing damaged tissue, the use of no foreign material, ensuring an adequate blood supply, complete rest to the part, and the avoidance of antiseptics, which have no place in the modern treatment of civil wounds.

Duodenal Suction has been a great boon to patient and surgeon alike. Enterostomies, a very common operation a few years ago, and often life-saving, are becoming very infrequent. A modification of duodenal drainage by a Levine tube is the use of a Miller-Abbot tube. This tube is a long two way rubber tube with an air filled bag attached to the end allowing it to be passed down the bowel to aspirate the jejunum and ilium. Its use is often attended with great difficulties and failures are frequent, but a success with it is often brilliant. It is an advance but its usefulness is limited in its present form.

Surgery of the Stomach

The greatest problem in the surgical treatment of gastro-duodenal ulceration is lack of any definite knowledge as to the etiology of these conditions. When the cause is known it is unlikely that surgical care will ever be required for these ailments, but at present there is a very distinct trend toward radicle treatment or medical treatment. A chronic gastric ulcer is an ideal case for a partial gastrectomy; the mortality is low and the end results are good. Many techniques are advocated by various men, but the variations are usually of an artistic character. The essential of the operation is the same, namely, removal of the distal 3/5 of the stomach including the ulcer and the pylorus, and the anastomosis of the jejunum to the remaining pouch. A duodenal ulcer presents a much different problem. Here operation is usually reserved for complications, perforation, obstruction or repeated haemorrhage. For obstructed cases and elderly people with a low acid, gastro-enterostomy is the operation of choice. For younger people with high acid gastric resection is advocated by most men. Whether this is the correct procedure for this difficult class of case is hard to say. The old saying may hold true here, "All operations for duodenal ulcer are successes until they are found out". Schiassi of Bologna advocates denervation of the stomach and duodenum regardless of the operation performed.

Haematemesis

At present this is a much written about subject. It is a well known fact that the first haemorrhage carries with it little risk to life, but repeated and massive haemorrhages are dangerous, and call for surgical treatment before a fatal one occurs. In gastric ulcer, gastrectomy is ideal. In a duodenal ulcer, where the ulcer can be removed along with the stomach, this suffices, but when it can not some direct attack on the ulcer and vessels leading to it must be undertaken. This is necessary because most fatal cases are due to bleeding of a large vessel in the base of an ulcer, analagous to a secondary haemorrhage occurring in any ulcer.

In a recent article Gordon-Taylor urges that an attempt be made to diagnose these serious cases and to operate on them as soon as they are prepared, otherwise most of them die. If operation is to be done it must be within the first 48 hours, as advocated by Finsterer.

Hypertension

The surgical treatment of hypertension is varied, ranging from nephrectomy, renal decapsulation, excision of part or all of an adrenal gland or denervating them, to attacks on the sympathetic nervous system at various levels.

That the kidneys have some effect on the blood pressure is confirmed by the fact that remarkable cases are published from time to time on the lowering of blood pressure after the removal of a grossly deformed kidney either congenital or acquired.

Camelot and Langeron decapsulated the kidneys of 5 severe hypertensions and obtained remarkable drops in blood pressure, but these were not maintained.

Peet, one of the advocates for splanchnicectomy, believes that essential hypertension is due to spasm of the renal arteries, giving rise to impairment of renal function with the formation of a pressor substance in the kidney which is then absorbed and affects the entire systemic system. His belief is that resection of the splanchnics prevents spasm of the renal arteries. Many operations have been suggested. Resection of the splanchnics was first suggested by Danielopolu in 1923 and done by Pieri in 1930. The patient, a man of 67, B.P. was 200/110, 2 years after operation the B.P. was 165/90. Many hundreds of cases have been done since then with varying results. The lowering of the blood pressure may be transient but the relief of the symptoms may be prolonged. Some cases are apparently cured. Adson's operation of anterior rhizotomy from the 6th thoracic to the 2nd lumbar is a more difficult operation and apparently no more effective. For the present, attacks on the adrenals for essential hypertension have ceased.

Goldblatt has succeeded in producing hypertension in dogs after excision of one adrenal and destroying the medulla in the other. His method is using a constricting metal ring around the renal arteries and so reducing their blood supply.

At present the most popular operation is splanchnicectomy, performed either above or below the diaphragm, and when a case responds to rest in bed and vasodilator drugs and these measures bring about a significant fall in blood pressure and retinal damage is only moderate, splanchnicectomy is justifiable.

Surgery of Heart Disease and Heart Disease in Surgery

Foged and Geill in an investigation of 353 cases about to undergo operation, and in whom there was no clinical evidence of heart disease, found

abnormalities by electrocardiograph tracings and X-Rays in 100. The mortality in the 253 normal cases was 1.1% and in the 100 with abnormalities 11.3%. They maintain that operations on patients with coronary sclerosis and myocardial degeneration should only be undertaken in order to save life.

It is being definitely shown that pericardiectomy is a very worth while operation in chronic constrictive pericarditis. Churchill, in a paper in the *Annals of Surgery*, considers the results striking; of 10 patients operated on 6 were cured, 2 were 75% cured, one could do sedentary work, and one died. He warns that no attempt should be made to institute surgical treatment during the active stages of the disease, but only when scarring has taken place and it is assumed that the scar is constricting the heart should operation be done. The operation is carried out under intratracheal anaesthesia and the pericardium is removed piecemeal.

Some German authors recommend a preliminary Brauer's Cardiolysis, performing pericardiectomy at a later date, but there is no proof that this is necessary or advisable.

The surgical treatments of coronary sclerosis and angina pectoris are many, varying from total thyroidectomy, attacks on the sympathetic nervous system, to suggestions of cardio-pneumopexy.

These operations can be grouped

- (a) Thyroidectomy—which has nearly had its day.
- (b) Grafting operations.
- (c) Operations on the sympathetic nervous system.

Improvement of the blood supply to the heart by means of a graft was introduced by Beck. After much experimental work on dogs he came to the conclusion that the coronary arteries are not necessarily end arteries, they may anastomose with aortic branches in the fat at the base of the heart and that adhesions to the myocardium were vascularized and supplied some blood to it. O'Shaughnessy reports an autopsy on a case dying of carcinoma in which both coronary arteries were obliterated, but who in life had never shown any signs or symptoms of cardiac distress. Beck's operation consists of placing a pedicle graft of the pectoral muscle on the left ventricle after placing some powdered beef bone on the surface of the heart to induce inflammatory adhesions between the heart and pectoral muscle. His indications for operation are:

- (1) Accurate diagnosis of coronary sclerosis.
- (2) Failure of medical treatment to produce relief of symptoms.
- (3) Absence of marked circulatory failure.

O'Shaughnessy modified Beck's operation by bringing up the omentum through the diaphragm and attaching it to the heart.

An experimental operation has been done by Lezius on dogs, in which the left lung is brought through pericardium and sutured to the heart.

Whether these operations will stand the test of time is uncertain. Many very encouraging successes have been reported as a result of their use, but with a disease like coronary sclerosis, where the prognosis is difficult and often very uncertain, any results of treatment must be looked on with scepticism regardless of published results. I do not mean that these operations are not worth trying. In my own opinion I think they are. It is only by accumulating numerous cases from many centres that a true evaluation can be arrived at.

Operations on the sympathetic nervous system comprise such procedures as removal of portions of the cervical sympathetic, or stellate ganglia or alcoholic injections of the upper dorsal ganglia. The older operations in the neck, modifications of Jonnescos, in which the inferior cervical ganglion and the first and second left thoracic ganglia were removed, are all aimed at removal of the efferent pain fibres from the heart, the efferent paths for the cardiac reflexes passing up in the vagus. These are all somewhat uncertain in action and rather unsound theoretically.

Recently Raney has introduced a new operation based on a different physiological basis.

Anrep and Segall have shown that sympathetic impulses under normal conditions can induce coronary dilatation, but when conditions are altered by arterio-sclerosis or changes in the hydrogen-ion concentration the action is variable and often reversed; it is known that the action of afferent impulses depends on the condition of the myoneural junction rather than the character of the impulse.

That coronary spasm does occur during an attack is assumed. No one has seen the coronary arteries during an attack, but other signs of sympathetic over-activity are evident, peripheral vasoconstriction, perspiration and tachycardia, adrenalin aggravates the attack, nitrites and such drugs relieve the spasms.

To remove the preganglionic afferent impulses Raney sections the rami communicantes of thoracic 2, 3, 4, 5 and sections the chain below the 5th ganglion. This leaves the major part of the sensory mechanism of the heart intact and so the pain mechanism is still present, removing one of the physician's criticisms of sympathetic surgery in Angina.

Protrusion of the Intervertebral Discs

Although Adson in 1922 reported a case where a cervical disc was removed for quadriplegia, it was not until 1932 that Schmorl published his classical work on this subject. Since then many papers have been written. That this condition

exists, causes symptoms which can be cured by removal of the protrusion, no one will deny, but whether it is as common and whether the results are so uniformly good as some papers would lead one to believe, is problematical.

Trauma to the back at some previous time is present in about 80% of cases. This injury usually ruptures the annulus fibrosus, through which the nucleus pulposus protrudes; in some cases apparently the whole disc is displaced.

The symptoms produced are those of an extra-medullary spinal tumor. Pain referred along a nerve root is common. The nerve most commonly involved is the sciatic. Actual paralysis is not usually present. One would think this would be common because the protrusion is into the anterior part of the cord. An explanation of this may be in the fact that the nucleus pulposus is soft and pulpy, and accommodation takes place before any fibrosis occurs in the disc.

The final diagnosis depends entirely upon radiographic evidence after the injection of Lipiodal.

Treatment consists of laminectomy, with either extra or intra-dural removal.

These are a few of the advances made in surgery in recent years. Many others have occurred, and surgery is changing gradually, new areas are being invaded, and operations which once were popular are now rarely done.



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Manitoba's Venereal Disease Campaign

Inspired by the good results in Scandinavia, Surgeon-General Parran launched a great anti-syphilis campaign in the U.S.A. in 1936. Outspoken magazine and newspaper articles and radio addresses quickly overcame the "hush-hush" attitude of the general public and did very valuable educational work. Hundreds of new public clinics were established, many large firms had their employees blood-tested, and many states enacted compulsory pre-marital blood-testing. The benefit of the American educational campaign was, of course, felt in this country, and, in addition, the Manitoba Public Health Department has conducted a campaign of its own. An important article on this subject can be read elsewhere in this issue.

The medical profession has an extremely important duty in co-operating with the Department of Health in each case of venereal disease. As soon as a diagnosis is confirmed, in a previously unreported case the physician enters the patient's name in his own official Department of Health V.D. report book. A corner of the sheet containing only the patient's number, diagnosis and source of infection is then sent post-free to the Department. A pamphlet on the disease is given to the patient and also a slip with his number warning him that if he does not report regularly for treatment he can be forced to do so by law. All recent

cases should be carefully questioned re possible sources of infection and contacts and the names of these sources and contacts sent to the department so that they can be sent a registered letter asking them to go to their own doctor or a government clinic for examination. Delinquents can be interviewed by public health nurses, or, in extreme cases, arrested by the police.

It will be noted that this system preserves the anonymity of the patient as long as he continues treatment. Apart from the statistical value of having cases reported to the department the patient is impressed by the public health aspect of his disease and by the fact that society can compel him to take treatment if he is delinquent. But the paramount virtue of the reporting system is the immense gain to the health of the community by the tracing and treatment of sources of infection. The physician cannot do this himself, but the department is only too pleased to do it for him. No doctor would be content to treat a patient with rabies and ignore the rabid dog. Let us all do our part in faithfully reporting cases and contacts to the department.

F.G.A.

Post-Operative Prostigmin

or

Pity the Weary Interne

Acting on a theoretical suggestion in the prostigmin editorial in the July number, a number of physicians and surgeons in the General Hospital have tried one oral tablet of prostigmin to evict the gaseous contents of crampy post-operative or heart failure intestines or the fluid contents of distending post-operative or cord bladders. This harmless 10c treatment has frequently made the weary interne lay his catheter by, and the happy orderly bless the uses of pharmacology.

When enough cases have been collected a formal report will be issued. This is a preliminary communication.

F. G. A.

Medical Society Notes

The North-West Manitoba Medical Society held its August meeting at Virden on the 14th. There was a good turnout of members and visitors. Doctors Charles Hunter and A. R. Birt, from Winnipeg, were present and gave papers, the former on "Some Common Medical Errors in General Practice," and the latter on "Those Irritating Rashes of Summer Time." Both were most instructive. In the evening, dinner was served in the Central Hotel. There will be no meeting of this Society in September, as in that month the M.M.A. holds its annual meeting. The October meeting will be held in Birtle on the second Wednesday of the month.

OBITUARY

DR. JAMES McKENTY

One of the foremost surgeons of Western Canada, Dr. James McKenty, died at his residence in Winnipeg on August 11, at the age of 74.

Born at Collins Bay, near Kingston, Ont., he graduated in medicine from Queen's University in 1889, practiced at Neche, N.D., with the late Dr. P. C. Donovan, then with his brother, Dr. F. D. McKenty, at Gretna, and came to Winnipeg in 1902. In 1904 he was appointed to the Faculty of the Medical College as Lecturer in Anatomy. Later he was Assistant Professor in Clinical Medicine and then Associate Professor of Surgery, and finally Emeritus Professor of Surgery. For many years he served on the staffs of St. Boniface, Misericordia and St. Joseph's hospitals, mostly as Chief of Staff. More than one generation of medical students sat under him, observed his methods and admired the workings of an admirably clear and logical mind.

His interest in surgery led him to take post-graduate work in Berlin and Vienna in 1911 and 1928. He was keenly interested in education, hospital administration and medical economics. For eight years he represented St. Paul's College in the Senate of the University of Manitoba.

Golf was almost his sole recreation, but in later years he travelled extensively.

He was President of the Winnipeg Medical Society, Fellow of the American College of Surgeons, and an active member of the Manitoba Medical Association and the Canadian Medical Association. Several of his papers on surgical subjects, notably surgery of the gall bladder and intestinal obstruction, appeared in the Canadian Medical Association "Journal." He did much to raise surgery in Western Canada to a higher plane during his practice extending over forty years.

BOOK REVIEW

The Australian Army Medical Services in the War of 1914-1918—Volume II, by Colonel A. G. Butler, D.S.O., V.D., B.A., M.B., Ch.B. (Camb.), with 212 illustrations, maps and graphs: — Australian War Memorial, Canberra, 1940. 21s. net.

The Australian War Memorial, Canberra, has recently published the second volume of the history of the Australian Medical Services in the War of 1914-1918 under the editorship of Colonel A. G. Butler. The first volume, which appeared several years ago, dealt with the Australian Medical Services in Egypt and Gallipoli. The original project called for completion of the history in two volumes, but when the second was being written, it became evident that a third volume would be necessary to deal with the highly important questions of post-war treatments and of pensioning. The second volume deals with the Australian Medical Forces in France during the years 1916, 1917 and 1918, and ends with the armistice. It is a portly volume, which, with text, appendices and index, numbers over one thousand pages.

One must admit that it is not light reading, but a serious contribution to military history cannot be expected to provide diversion for summer afternoons. The editor has tried to lighten the burden of the casual reader by having the main thread of the narrative set in larger type. The illustrations are mainly from photographs, the frontispiece appropriately being a portrait of Major General Sir Neville R. House, who was Director of Australian Medical Services through-

out the war. A reproduction of a drawing by Will Dyson, "Stretcher-Bearers near Martinpuich," has caught the very spirit of these devoted men.

The military operations dealt with in this work include the first Somme offensive of 1916, the German retirement of 1917, the Flanders offensive including Messines and the Third Battle of Ypres which brought attrition warfare to an end, the German thrust for victory in March, 1918, the Allied counter-offensive, the Battle of Amiens, the Hindenburg Line, and the war of movement. Each type of military operation, trench warfare, the war of attrition, the German breakthrough, the allied counter-offensive and the rapid movement following the breaking of the Hindenburg Line produced varied medical problems in collecting, sorting, transporting and treating casualties, the prevention of illness, sanitation, and of overcoming "wastage." Especially for the Australian Corps did this latter problem become exceedingly acute toward the end of the war. This Corps was composed wholly of volunteers from an island continent eleven thousand miles or more from the scene of action. Physique and morale were equally high in this splendid fighting force, and these qualities caused them to be used extensively as shock troops. Casualties were great and towards the end of the war both the number and the physical fitness of recruits fell off. It was not the least important duty of the Australian Medical Services to offset this wastage, and to ensure "return to duty" whenever possible.

In addition to the story of the relation of the medical services to military operations, the editor gives an excellent summary of the varying treatment of war wounds, ending in final agreement on excision (débridement) of the wound with primary or secondary suture, of research into the nature and cause of wound shock with resultant "resuscitation" treatment through warmth, morphine and transfusion, of the recognition of the value of the Thomas hip splint, and, on the medical side, of the tremendous value of preventive medicine. Colonel Butler calls attention to the creation in 1918 of an Advanced Dressing Station which became a model for similar stations, and to the excellent work of Major A. W. Holmes, a Court, A.A.M.C., in directing a resuscitation team in the main dressing station of a field ambulance. Another highlight of this history is the story of the co-operation of Australian field ambulances with medical services of the Second American Corps in the battle of St. Quentin Canal.

Most important, perhaps, of all the themes discussed, and there are many, is the value of the medical services in the military scheme in ensuring the physical fitness of line troops and of keeping up morale: "the soldier himself knew that, if he was hit, nothing that flesh and blood could do toward saving life and health and alleviating pain would be left undone." The value of the medical services in the military organization was increasingly recognized with the progress of the war.

Canadian readers will note with pleasure the reference to No. 3 Canadian C.C.S. (Lieut.-Colonel R. J. Blanchard, Winnipeg) at Remy Siding and to the disinfecting apparatus devised by Major Orr, C.A.M.C., of Edmonton.

Now when another struggle is shaking the whole earth, this history takes on a new significance, not as a chronicle of "old, unhappy, far-off things and battles long ago," but as a recital of the successful efforts of men taken from the relative order and simplicity of civil life to adapt themselves to the strain and stress of world conflict, and in that welter of horror to form a smoothly functioning organization which waged unrelenting war against disease, pain and death. No member of a medical unit now on active service can read this book without finding something of particular value to him in his own work. This volume is indeed a fitting memorial of the great work of the Australian medical forces in the war of 1914-1918.—R.B.M.



"An ounce of prevention"

One of the most effective methods of preventing untoward menopausal symptoms is through the early use of "Emmenin". As Hawkinson* has suggested, "Patients at the menopause who are still menstruating may be more difficult to control . . . Oral therapy in the form of emmenin is best suited to these cases."

*Hawkinson, L. F.: J.A.M.A. 111:392 (July 20) 1938.

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Personal Notes and Social News

Conducted by Gerda Fremming, M.D.

Dr. and Mrs. Earl Stephenson are receiving congratulations on the birth of a daughter, July 24th, at St. Boniface Hospital.

* * *

Dr. and Mrs. G. H. Hamlin, of Portage la Prairie, Man., spent a short vacation at the Lake of the Woods.

* * *

Dr. Leon Benoit and his daughter, Jacqueline, enjoyed a month's vacation at West Hawk Lake.

* * *

Dr. and Mrs. Donald Whyte (nee Eileen Talbot-Crosbie) of Owen Sound, Ont., are accepting congratulations on the birth of a son (John Donaldson).

* * *

Dr. W. G. Riddell, of Beausejour, Man., has left for Ottawa to join his unit, the Medical Corps of the R.C.A.F. His family accompanied him as far as Niagara Falls, Ont.

* * *

Dr. and Mrs. Gordon Chown and family spent a short holiday in the Lake of the Woods district.

* * *

Dr. and Mrs. C. M. Thomas and son Carleton, of Rivers, Man., were vacationing at Delta during the first part of August.

* * *

The Association extends its deepest sympathy to Surgeon Lieut.-Commander C. W. MacCharles on the loss of his father, who died August 1st, in his 91st year. Also to Dr. R. W. MacCharles, who was a brother.

* * *

Dr. and Mrs. W. Morrison, of Gilbert Plains, Man., were holidaying in Winnipeg for two weeks.

* * *

Dr. and Mrs. Kenneth C. McGibbon have taken a cottage at Matlock Beach for the month of August.

* * *

Dr. and Mrs. W. J. Boyd of Roland, Man., were week-end visitors in Winnipeg.

* * *

Dr. J. A. Bildfell, a graduate of the University of Manitoba, has left his practice in Wynyard, Sask., to take charge of the hospital at Pangnirtung, Baffin Island, where he will administer to the medical needs of 40 Whites and over 2,000 Eskimos, as well as acting as justice of the peace and coroner.

* * *

Dr. John Charles Elias, oldest son of Mr. and Mrs. Peter Elias of Carman, Man., was united in marriage July 27th to Ada Viola, youngest daughter of Mr. and Mrs. L. Eby of Carman. Dr. and Mrs. Elias left for Kenora on their honeymoon.

Dr. and Mrs. Daniel Nicholson are spending a three weeks' holiday trip to Prince Edward Island. While there they will visit their home and renew old acquaintances.

* * *

Dr. T. E. Holland has been promoted to the rank of Lieut.-Colonel, Canadian Army Medical Corps, C.A.S.F., and will be in command of Fort Osborne Military Hospital, Winnipeg.

* * *

Lieut.-Colonel P. G. Bell is detailed for duty as district medical officer of Militia District 10, Winnipeg.

* * *

Dr. F. D. McKenty has returned from a holiday trip to Jasper Park, Alta.

* * *

The glad hand—the cordial smile—the kindly thought—all were extended to Mr. J. L. Hewitt of the Medical Business Bureau when he visited his office for the first time today (August 19th) after an illness that kept him confined to his bed for over three months.

* * *

GOLF—Cups in golf come under two categories.

In order to distinguish one cup from another we will call the elusive HOLE on the green a cup and our subject a Mug and what a handsome Mug the Manitoba Medical Association Cup is. It's a trophy any member would be proud to hold. It is yours for the taking, providing—you TAKE less strokes than the other fellow when it will be competed for on Saturday afternoon, September 21st, over the sporty Niakwa Country Club course. Teeing off time is from 1.30 to 3.00 p.m. All medical practitioners in Manitoba are eligible as this is a provincial competition. Forward your entries early please, to 102 Medical Arts Building.

Winners of the Winnipeg Medical Golf tournament August 21st were as follows: (1) Dr. W. A. Gardner, (2) Dr. F. A. Young, (3) Dr. N. W. Warner.

* * *

"A man comes to our house every single day" so the words of a popular song go, but it took five years for a little Runt in a leaky Punt to come around at the most inopportune time when one of our well known medicos was holidaying in the Lake of the Woods district. Being a law abiding citizen "G. C." had always procured a fishing license ever since he graduated from the hickory limb, cotton twine and bent pin class. When the little Arm of the Law came along, not a FIN of guilt could be seen, the evidence was purely circumstantial. He was reeled in for \$3.25 or the option of losing everything, including his shirt.

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Manitoba Medical Association

In Conjunction with the Canadian Public Health Association

Annual Meeting Programme

WEDNESDAY, SEPTEMBER 18th

Presidential Dinner to the Retiring Executive

THURSDAY, SEPTEMBER 19th

Morning

Fort Garry Hotel

8.30 Registration.

Winnipeg General Hospital

9.15 Surgical Clinic.

West two and west three balconies (simultaneously).

Chairman, DR. C. W. BURNS.

The Diagnosis and Emergency Care of Head Injuries.

PROF. O. S. WAUGH.

The Indications for and a Practical Demonstration of Sigmoidoscopic Examination.

DR. P. H. T. THORLAKSON and Associates.

Abdominal Cases — Chosen from Available Patients Under Treatment.

DR. C. W. BURNS and DR. J. HILLSMAN.

Some Aspects of Hyperparathyroid Disease.

DR. G. S. FAHRNI.

Treatment of Urinary Tract Infections.

DR. H. MORSE.

Pulmonary Sepsis — Lobectomy.

DR. M. B. PERRIN.

Fracture Demonstration.

DR. A. GIBSON.

11.00 Tumor Cases to be presented by Drs. M. R. MacCharles and A. W. S. Hay and others who have cases available for diagnosis or treatment.
Chairman, DR. DANIEL NICHOLSON.

12.15 Luncheon.

Guests of Winnipeg General Hospital.

Afternoon

Fort Garry Hotel

2.00 Symposium: On Maternal Welfare.

Chairman, DR. J. A. FERRELL, Assistant Director of International Health Division of the Rockefeller Foundation.

Preliminary Report on Maternal Deaths Arising from Maternal Mortality Survey.

DR. F. W. JACKSON.

Discussion arising out of report.

Abortion.

DR. J. D. McQUEEN.

Toxaemia.

DR. ROSS MITCHELL.

Intermission (15 mins.): Inspection of Exhibits.

Puerperal Sepsis.

DR. BRIAN BEST.

Haemorrhage.

DR. F. G. McGUINNESS.

Accidents of Pregnancy and Labour.

DR. S. KOBRINSKY.

(Papers to be fifteen minutes. Discussions ten minutes).

Evening

Fort Garry Hotel

7.00 Dinner and Business Meeting.

Short Address by the President of the Canadian Medical Association.

Note—The Surgical Clinics of September 19th at the Winnipeg General Hospital will be carried on simultaneously on W/2 and W/3 balconies. The groups will, therefore, be smaller, so that visiting doctors may take part in the examination of patients and discussion. The same plan applies to the Medical Clinics on Friday, September 20.

FRIDAY, SEPTEMBER 20th

Morning

Winnipeg General Hospital

9.00 Medical Clinic.

"A" West two balcony.

Chairman, DR. C. R. GILMOUR.

9.30 Duodenal Stasis.

DR. C. HUNTER.

10.00 Endocrine Therapy.

DR. LENNOX G. BELL.

10.20 Interpretation of Some Practical Clinical Tests.

DR. F. GERARD ALLISON.

11.00 The Significance of Some Neurological Signs.

DR. G. L. ADAMSON.

9.00 "B" West three balcony.

Chairman, DR. J. D. ADAMSON.

9.30 Sulpha-pyridine (Dagenan) in Pneumonia.

DR. A. B. HOUSTON and DR. J. D. ADAMSON.

10.00 Sulpha-pyridine in Meningitis and Undulant Fever.

DR. H. D. KITCHEN.

10.30 Chest Pain and Cardiac Disease.

DR. J. M. McEACHERN.

11.00 Some Psychological Problems in Practice.

DR. A. T. MATHERS.

Time will be allowed for thorough discussion, and it is hoped that the visiting clinicians may contribute.

Winnipeg, September 19-20-21

Headquarters, Seventh Floor

Fort Garry Hotel

FRIDAY, SEPTEMBER 20th --- Cont.

Afternoon

Fort Garry Hotel

12.15 Joint Luncheon with the Canadian Public Health Association.

Intermission: Inspection of Exhibits.

2.00 Medical and Surgical Aspects of Duodenal Ulcer.
DR. DUNCAN GRAHAM, Toronto.

Present Day Views of the Surgical Treatment of Duodenal Ulcer.

DR. P. H. T. THORLAKSON.

Intermission (15 mins.): Inspection of Exhibits.

Subject to be announced in Child Hygiene.

DR. E. COUTURE, Director Child and Maternal Welfare Division.

The Nutrition Problem in the Child Health Programme.

MISS ANNA SPEERS, M.A., Nutritionist, Children's Hospital.

The Prophylaxis and Therapy of Whooping Cough.

DR. H. MEDOVY.

Evening

Fort Garry Hotel

7.30 Annual Dinner and Dance.

The Manitoba Medical and Canadian Public Health Associations join for this event.

Feature of this dinner will be the presentation of Honorary Life Memberships in Canadian Public Health Association to Dr. E. W. Montgomery, Professor Emeritus in Medicine, University of Manitoba, and formerly Minister of Health and Public Welfare, Province of Manitoba; and to Hon. J. M. Urich, M.B., Minister of Public Health and Provincial Secretary, Province of Saskatchewan, and Hon. President of the Canadian Public Health Association.

Dancing — Entertainment.

SATURDAY, SEPTEMBER 21st

Morning

St. Boniface Hospital

9.00 Indications and Technique of Uterography.

DR. M. S. RADY.

Thyroid Disease in Children.

DR. A. C. ABBOTT.

Congenital Anomalies.

DR. J. C. HOSSACK.

Presentation of Clinical Cases from Tumour Clinic.

DR. DIGBY WHEELER, Chairman, and Members of Tumor Service.

11.30 Recent Advances in Fractures (Slides).

DR. J. H. COUCH, Toronto.

Afternoon

St. Boniface Hospital.

12.15 Luncheon.

Guests of St. Boniface Hospital.

1.30 Annual Golf Tournament.

Niakwa Country Club.

LADIES' PROGRAMME

THURSDAY, SEPTEMBER 19th

Afternoon

3.30 Tea at the residence of Mrs. W. E. Campbell, 246 Waverley Street.

FRIDAY, SEPTEMBER 20th

Afternoon

1.00 Luncheon.

Wives of the members of the Retiring Executive will be guests of Mrs. W. E. Campbell at the University Women's Club.

Evening

Fort Garry Hotel

7.30 Annual Dinner and Dance.

Individual invitations to the tea are not being sent this year but wives of all members are very cordially invited.

It is requested that wives of visiting doctors get in touch with our Registration Committee, located at the Fort Garry Hotel upon arrival.

LADIES' COMMITTEE

Mrs. George Brock
Mrs. W. G. Campbell
Mrs. A. M. Goodwin
Mrs. S. G. Herbert
Mrs. F. W. Jackson

Mrs. H. D. Kitchen
Mrs. H. Medovy
Mrs. H. Morse
Mrs. E. W. Stewart
Mrs. Digby Wheeler
Mrs. W. E. Campbell.

PUBLIC MEETING

Auditorium Concert Hall, Thursday, September 19th, 8:30 p.m.

Chairman, MR. R. G. PERSSE, President of Cancer Research Institute.

Cancer and Its Control.

DR. HAROLD WOOKEY, Toronto, under the aegis of Department of Cancer Control C.M.A.

Venereal Disease.

DR. D. H. WILLIAMS, Vancouver.

These lectures should be of interest to every citizen. Wives of the members and their friends are urged to attend this meeting.



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Sulfathiazole is effective also against other pathogenic organisms, but its general clinical application in such infections should await the published reports on various investigations still in progress.

Write for literature which discusses the indications, dosage and possible side effects of Sulfathiazole.

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Department of Health and Public Welfare

Venereal Disease Control in Manitoba

The title above might perhaps be better taken as "The Attempt Being Made to Control Venereal Disease in Manitoba." However, we do feel that we are making at least some headway and that our machinery of control is functioning more efficiently and running more smoothly as time goes on.

Method of Spread

We are all, I am sure, conversant with the methods of spread of this type of infection. Some of it is accidental, some congenital, but the greatest percentage is due to intimate contact between persons during the period while one of them is infectious. As it is a disease of humans only, each new case must come from a former case no matter what the method of infection. Recognizing this fact, it becomes obvious that each case is a reservoir (and possible focus of infection) and that to wipe out the disease it is necessary to treat every case until it is rendered non-infectious and to eliminate contact with others from the time of initial infection until sufficient treatment has been given to remove the danger. This sounds very simple but in practise it is not so simple; even so, it must be our target.

Much Venereal infection is acquired innocently but much more of it, not so innocently! Alcohol has always been a great ally of Venereal Disease. Consequently syphilis and gonorrhoea have always been classed as dirty diseases and thought by the average citizen to be entirely due to moral vice. Little or no thought was given to the innocent victim of accidental or congenital infection, or to infection by a not so innocent marital partner. This opinion by the general public caused such infection to be hidden. Treatment was only applied for when life became too miserable to stand without it. Accurate knowledge regarding these diseases was difficult to obtain because "decent" people would not even mention them. Quacks flourished on the common ignorance, disease became widespread, and the infection (from lack of proper treatment) deep rooted. This "Hush, Hush" attitude has been one of the most difficult obstacles to overcome. It has driven persons away from treatment rather than toward it and so tries to defeat our efforts toward getting every case on treatment in the early stages.

Education

How can we overcome this obstacle? By education!

When people have been taught that syphilis and gonorrhoea are simply communicable diseases and that they are each caused by a specific germ which can be recognized under a microscope; that these diseases can be easily diagnosed and if prompt and regular treatment is carried out cure is almost certain, then they will come for treatment willingly and in the early stages.

The Department of Health and Public Welfare has done and is doing a great deal along this line by lectures, radio talks, pamphlets and magazine articles. The family physician can give us great assistance by giving honest, straight-forward and encouraging advice to all those coming to his office with their worries and troubles. Our Regulations forbid the treatment of these diseases by anyone other than a physician and this also applies to the sale of drugs or appliances excepting on a physician's prescription. It is also forbidden to print or distribute literature recommending treatment of Venereal Disease by drugs or appliances not approved by the Minister of Health and Public Welfare. This is to discourage quackery and the dissemination of false information.

Case Finding

Our aim is to get every case on treatment and to keep it on treatment until cured or at least rendered non-infectious. The first problem then is case finding. Due to our educational campaigns many come of their own accord. From them histories are obtained and the names of sources and contacts received when possible. These sources and contacts are written to by registered letter (by the Department of Disease Prevention) requesting that they go to their own physician or to a Government Clinic for examination and that a report as to the findings of such examination be sent to the Department. If the report shows Venereal Disease infection they are reported as cases and ordered to remain on treatment. If our letter does not produce results, one of our Public Health Nurses makes a visit, discusses the situation with them and endeavors to arrange for this examination. All else failing, we get an affidavit or declaration from the patient giving their name as the source of infection, and the Minister may then issue a warrant authorizing examination of such suspect. If found to be infected with a Venereal Disease and in an infectious stage then the Minister may by warrant have such person apprehended and held for a period of two weeks for further examination and investigation. At the completion of this period, if further treatment is required a further detention warrant is issued by the Minister and the patient is held in custody and receives treatment until rendered non-infectious.

Our Regulations give the Minister wide powers as to the examination of persons suspected to be suffering from Venereal Disease. These powers are only invoked after trying all other methods to get patients on regular treatment, but they are invoked when necessary. Under the Regulations any person who has been committed to a gaol or other place of detention upon conviction for an offence under the Criminal Code of Canada, or under any Act of the Province of Manitoba, and whenever any person is under arrest or in custody charged with an offence under the Criminal Code of Canada the Minister may order an examination by a qualified physician to ascertain whether such person is infected with Venereal Disease. If found to be infected they are detained and isolated for treatment whether found guilty of the original charge or not. At the termination of sentence if still infectious they are detained for a further term until considered safe to be at large.

Reporting Cases

Under our Regulations it is an offence to knowingly infect any other person with a Venereal Disease. Every physician treating a case of Venereal Disease must report it by serial number on the prescribed form to the Minister within twenty-four hours. Every person suffering from Venereal Disease must personally attend for treatment at least once in every two weeks. Change of physicians must be notified to the Minister. Failure to attend for treatment during a period of one month makes it obligatory upon the attending physician's part to report on the prescribed form to the Minister that the patient is delinquent. We immediately write the patient by registered letter ordering return to treatment and explaining the advisability and Regulations. If after considerable effort and a visit by our Public Health Nurse they do not return for treatment, a warrant may be issued and they may be committed to gaol or hospital and treated there.

Free Treatment

The value of complete reporting of cases by physicians is most obvious. We must know where cases are and the extent of the problem to make provision

for and to be of most assistance in giving treatment and making sure that patients are attending regularly for treatment. Reporting is more complete than it was a few years ago, but is not yet as good as it should be. We ask every doctor to do his duty and report every case that he sees. We on our part are only too glad to assist him in every way possible. We supply arsenic and bismuth free for treatment of syphilitics who cannot afford to pay, and in parts of the Province where Government clinics are not available we pay the doctors for giving the treatments. We supply Keidel tubes for taking blood for Wassermanns, and encourage physicians to have Wassermanns on all suspicious cases and on all pregnant women. These Wassermanns are done free at the Provincial Laboratory. Dark field kits are also supplied.

We send out arsenic and bismuth in ten-week dosage packages in order that we may know in ten weeks if more is not ordered that the patient is delinquent. We then write the doctor and get his report and if he recommends "chasing" the delinquent back for treatment we do so. This follow-up on treatment is very important. We also see that the family of each case is checked up for infection.

Our Public Health Nurses do a very valuable work in making visits where necessary, having a personal talk with the patient, stressing the value of steady treatment and the methods of protection of others. Also the need to have the balance of the family examined if there is any possibility of their being infected.

The assistance and co-operation of the various Police Forces has been invaluable. Many of the women and men of "easy virtue" are known to the Police and it is not difficult to pick them up on certain charges and so have them examined and if infected, put out of circulation until rendered non-infectious. If they are attending for treatment but are inclined to lapse, a slight warning is all that is necessary in most cases. Of the total number examined while under arrest about 50% are found to be infected with either one or both venereal diseases. Not only has this brought many for treatment, but many others, knowing that if they were arrested and found to be infectious would be sent to gaol for treatment, have come in voluntarily for treatment at our Clinic.

We have established a free clinic in the St. Boniface Hospital where examinations are made and treatment given. Males have two days per week and females two other days per week. It is wise to keep them to separate days! We provide treatments in the various gaols and detention homes. The Brandon Health Unit is in charge of treatment for Brandon residents who cannot afford to pay for their treatment. Hospital care is available for those requiring this type of treatment.

Cases moving from one Province to another or to a State are reported to the proper authorities in that Province or State and so are kept on treatment. This arrangement is working very well and all Provinces are co-operating splendidly.

Results

We had expected the war to increase our number of cases. So far we have been agreeably surprised by the small number. This must be attributed to the prompt measures taken in the army such as (1) education, (2) prophylactic stations, (3) treatment, and to the hearty co-operation with the Department in reporting sources and contacts so that they may be put under treatment.

In 1939 we had 588 cases of syphilis reported (368 male and 220 female), and 872 of gonorrhoea (647 male and 225 female). We do not consider this to be 100% of the cases but it is a slight improvement over 1938. Another encouraging feature is that most of the cases of syphilis are coming in earlier and consequently

will require less treatment and have much more chance of cure and less of going on to the tertiary stage.

In 1939, 24,871 treatments were given free for syphilis and approximately 20,000 for gonorrhoea. Ninety-three delinquents were reported to us during the year. Many sources and contacts also were reported. In almost every case these were found, examined and placed under treatment if found to be infected. Sometimes the description of the sources and contacts is very meagre, but in most cases we are able to find them. We feel that the secret of success in Venereal Disease control will be:

- (1) The discovery and reporting of every case.
- (2) The prevention of contacts.
- (3) The provision of adequate treatment for every case.
- (4) The enforcement of the Regulation that they receive this treatment.

To do this we must educate the public as to the truth about Venereal Disease.

We hope that in the near future a pre-marital examination including Blood tests and smears will be made compulsory. It would be at least one step toward the prevention of innocent and congenital infection. Some enlightened couples are already asking for this for their own protection and for that of their expected children. We of the Medical profession can do much if we make an honest effort to control Venereal Disease.

Dr. M. B.

COMMUNICABLE DISEASE REPORT

June 18th to July 15th

Measles: Total 406—Unorganized 62, Thompson 45, Brandon 20, Transcona 18, Winnipeg 16, St. Boniface 16, Portage Rural 8, Albert 7, North Norfolk 5, Portage City 5, Edward 4, St. Andrews 4, Gimli Village 4, Rhineland 4, Woodlands 4, Arthur 3, Bifrost 3, Ethelbert 3, Hanover 3, Kildonan East 3, Franklin 2, Napinka 2, Dauphin Town 1, Fort Garry 1, Miniota 1, Morris Rural 1, Ochre River 1, Pipestone 1, St. Clements 1, Ste. Rose Rural 1, Shell River 1 (Late Reported: Unorganized 117, Woodlands 13, Brandon 11, St. Clements 7, St. Boniface 2, Ste. Rose Village 2, Transcona 2, Edward 1, Ethelbert 1).

Chickenpox: Total 167—Winnipeg 116, St. Boniface 13, Transcona 10, Unorganized 9, The Pas 7, Kildonan West 2, North Norfolk 2, Kildonan East 1, Montcalm 1, Portage City 1, Tuxedo 1 (Late Reported: The Pas 2, Daly 1, St. Boniface 1).

Whooping Cough: Total 79—Winnipeg 35, St. Boniface 16, Sifton 4, Albert 2, Portage Rural 2, Woodlands 2, Portage City 1, Melita 1, Fort Garry 1 (Late Reported: Flin Flon 5, Rockwood 4, Brandon 2, Edward 2, St. Andrews 1, Unorganized 1).

Scarlet Fever: Total 19—Winnipeg 12, The Pas 2, Bifrost 1, Brandon 1, Gilbert Plains Rural 1, Selkirk 1, Tuxedo 1.

Pneumonia (Lobar): Total 17—Brandon 1, McCreary 1, Ochre River 1, Ste. Rose du Lac Village 1, Ste. Rose Rural 1, Unorganized 1 (Late Reported: Brandon 1, Hamiota Village 1, St. Laurent 1, St. Vital 1, Springfield 1, Unorganized 1, Victoria 1, White-mouth 1, Bifrost 1, De Salaberry 1, Hanover 1).

Tuberculosis: Total 15—Winnipeg 12, Glenella 1, St. Boniface 1, Springfield 1.

Diphtheria: Total 13—Winnipeg 9, Cartier 1, Selkirk 1, Tuxedo 1, Unorganized 1.

Mumps: Total 9—Winnipeg 7, St. Boniface 1, Thompson 1.

Diphtheria Carriers: Total 8—Winnipeg 5, Springfield 2, St. James 1.

Erysipelas: Total 5—Winnipeg 4, Rosedale 1.
Influenza: Total 5—(Late Reported: Brandon 2, Coldwell 1, Dauphin Town 1, Sifton 1).
Puerperal Fever: Total 4—Grey 1 (Late Reported: Clanwilliam 1, Eriksdale 1, Unorganized 1).
Encephalitis: Total 2—(Late Reported: Stanley 1, Pembina 1).
Meningococcal Meningitis: Total 1—Ste. Rose Rural 1.
Typhoid Fever: Total 1—The Pas 1.
German Measles: Total 1—Brandon 1.
Undulant Fever: Total 1—(Late Reported: Ste. Rose Village 1).
Treaty Indian Cases: Total 1—Meningococcal Meningitis 1.
Venereal Disease: Total 111—Gonorrhoea 77, Syphilis 34.

DEATHS FROM ALL CAUSES IN MANITOBA
For the Month of June, 1940

RURAL—Cancer 24, Pneumonia (other forms) 12, Tuberculosis 11, Influenza 7, Pneumonia Lobar 7, Measles 2, Syphilis 1, Whooping Cough 1, other deaths over one year 154, other deaths under one year 23, Stillbirths 13. Total 255.

URBAN—Cancer 27, Tuberculosis 11, Pneumonia Lobar 3, Diphtheria 2, Whooping Cough 2, Erysipelas 1, Poliomyelitis 1, Typhoid Fever 1, other deaths over one year 148, other deaths under one year 18, Stillbirths 8. Total 234.

INDIANS—Tuberculosis 11, Pneumonia (other forms) 5, Influenza 3, Cancer 1, Whooping Cough 1, other deaths over one year 6, other deaths under one year 2, Stillbirths 2. Total 31.

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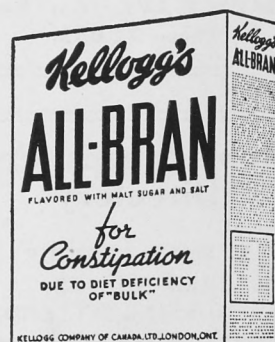
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